HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 1 2

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 USC 1396r-4; 42 USC 1396a(a)(13); 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 0
b. FFY 2003 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A(1), pages 4, 9, 10, 13, 18, 21, 22, 23

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Acute Inpatient Payment Systems

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12 (b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Wendy E. Warring

14. TITLE: Commissioner

15. DATE SUBMITTED: December 28, 2001

16. RETURN TO:
Bridget Landers
Coordinator for State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 31, 2001

18. DATE APPROVED: March 26, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL: Leona Renaud for R. Preston

21. TYPED NAME: Ronald Preston

22. TITLE: Associate Regional Administrator, DMSO

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

Managed Care Organization (MCO) - Any entity with which the Division contracts to provide primary care and certain other medical services to members on a capitated basis, including an entity that is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) or that otherwise meets the state plan definition of an HMO.

MassHealth (also referred to as Medicaid) - The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.

Member (also referred to as recipient) - A person determined by the Division to be eligible for medical assistance under the MassHealth program.

Non-Acute Unit – A Chronic Care, Rehabilitation or Skilled Nursing Facility within a Hospital.

Outlier Day - Each day during which a Member remains Hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of Hospitalization are not counted toward the outlier threshold as described in **Section IV.B.11**.

Pass-Through Costs - Organ acquisition, malpractice, and direct medical education costs that are paid on a cost-reimbursement basis and are added to the Hospital-specific standard payment amount per discharge.

Pediatric Specialty Hospital - An Acute Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit - A pediatric unit in an Acute Hospital in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994 exceeded 0.20, unless located in a facility already designated as a Specialty Hospital.

Primary Care Clinician Plan (PCC Plan) - A comprehensive managed care plan, administered by the Division, through which enrolled Members receive Primary Care and certain other medical services.

Public Service Hospital - Any public Acute Hospital or any Acute Hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 (see attached Exhibit 3) which has a private sector payer mix that constitutes less than twenty five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.

Rate Year (RY) – Generally, the period beginning October 1, and ending September 30; provided however, that RY 00 began October 1, 1999 and was extended through November 30, 2000. RY 01 begins on December 1, 2000 and has been extended through January 31, 2002.

and utilization data for Excluded Units were omitted from calculation of the statewide average payment amount per discharge.

The average payment amount per discharge in each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those costs and discharges from Excluded Units. Routine outpatient costs associated with admissions from ED and observation beds were included. The cost centers that are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Malpractice costs, organ acquisition costs, capital costs and direct medical education costs were excluded from the calculation of the statewide average payment amount per discharge.

The average cost per discharge for each Hospital was then divided by the Hospital's Massachusetts-specific wage area index and by the Hospital-specific FY98 all-payer casemix index using the Version 12.0 New York Grouper and New York weights. For the non-exempt Massachusetts Hospitals in the areas designated by the Geographical Classification Review Board of the Health Care Financing Administration, effective September 1, 1995, the average hourly wage of each area was calculated from the HCFA Hospital Wage Index Public Use File (FY97 Final, updated as of May 12, 2000). Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, BayState Medical Center's wages and hours were included. This step results in the calculation of the standardized costs per discharge for each Hospital.

The Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of MassHealth discharges for the Hospitals was produced. The RY01 efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75 percent of the total number of statewide discharges. The RY01 efficiency standard is $3,298.26.

The RY01 statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-five percent (95%); and by c) an inflation factor of 1.9% which reflects price changes between RY98 and RY99; by d) an inflation factor of 1.43% which reflects price changes between RY99 and RY00; and by e) an inflation factor of 2.4% which reflects price changes between RY00 and RY01. Each inflation factor is a blend of the HCFA market basket and the Massachusetts

Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the HCFA market basket to reflect conditions in the Massachusetts economy. The resulting statewide average payment amount per discharge is $2,815.34.

The RY01 statewide average payment amount per discharge was then multiplied by the Hospital's MassHealth casemix index adjusted for outlier acuity index (using version 12.0 of the New York Grouper and New York weights) and the Hospital's Massachusetts specific wage area index to derive the Hospital-specific standard payment amount per discharge (SPAD). The wage area indices were derived from the HCFA Hospital Wage Index Public Use File (FY97 Final, updated as of May 12, 2000).

The outlier adjustment is used for the payment of Outlier Days as described in **Section IV.B.9.**

Efficient low-cost Hospitals will receive an add-on to their SPAD as set forth in **Section IV.B.14.**

When groupers are changed and modernized, it is necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that the Division is following, and one that has been a feature of the Medicare DRG program since its inception. The Division reserves the right to update to a new grouper.

3. **Calculation of the Pass-through Amount per Discharge**

The inpatient portion of malpractice and organ acquisition costs was derived from each Hospital's FY99 DHCFP 403 report as screened and updated as of September 8, 2000. The pass-through amount per discharge is the sum of the Hospital's per discharge costs of malpractice and organ acquisition. In each case, the amount is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days and then multiplying the cost per diem by the Hospital-specific MassHealth (non-psychiatric/substance abuse) average length of stay from casemix data. The Division used the MassHealth audited Hospital-specific paid SPAD claims file for date of payment for the period June 1, 1999 through May 31, 2000 to develop the Hospital's RY01 casemix index.

The RY01 pass-through amount per discharge is the product of the per diem costs of inpatient malpractice and organ acquisition and the Hospital-specific MassHealth average length of stay from casemix data, omitting such costs related to services in Excluded Units.

The Division will make no additional payments to the Hospital or other entities (i.e., VNAs, home health agencies) for providing the services described in this section. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payer.

7. **Payment for Psychiatric Services in Distinct Part Psychiatric Units**

Services provided to MassHealth patients in Distinct Part Psychiatric Units who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which psychiatric or substance abuse services are provided to MassHealth Members assigned to the BHP or an MCO, except as set forth in **Section III.A and B**.

The regions used to develop the all-inclusive regional weighted average per diem rates correspond to the six Health Services Areas established by the Massachusetts Department of Public Health (PL 93-641). These regional weighted average per diems were calculated by a) dividing each Hospital's per discharge psychiatric rate established in the RY92 MassHealth RFA by the FY90 average length of stay pertaining to MassHealth psychiatric patients; b) multiplying the result for each Hospital by the ratio of the Hospital's MassHealth psychiatric days to the total MassHealth psychiatric days for the Hospital's region; and c) summing the results for each region. The regional weighted average per diems were updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; 3.16% to reflect price changes between RY95 and RY96; 2.38% to reflect price changes between RY96 and RY97; 2.14% to reflect price changes between RY97 and RY98; 1.90% to reflect price changes between RY98 and RY99; 1.43% to reflect price changes between RY99 and RY00; and 2.4% to reflect price changes between RY00 and RY01.

8. **Transfer Per Diem Payments**

a. **Transfer Between Hospitals**

In general, payments for patients transferred from one Acute Hospital to another will be made on a transfer per diem basis capped at the SPAD for the Hospital that is transferring the patient.

11. **Payments for Administrative Days**

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is the median calendar year 2000 nursing home rate for all nursing home rate categories, as determined by DHCFP. This base rate is $124.47.

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated for inflation using the update factor of 2.4% for inflation between RY00 and RY01. The resulting AD rates for RY01 are $162.89 for Medicaid/Medicare Part B eligible patients and $176.14 for Medicaid-only eligible patients.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for Outlier Days, as described above.

C. REIMBURSEMENT FOR UNIQUE CIRCUMSTANCES

1. Sole Community Hospital

The RY01 standard inpatient payment amount per discharge for a Sole Community Hospital (as defined in **Section II**) shall be equal to the sum of:

> 95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific RY01 pass-through amount per discharge, direct medical education amount per discharge, and the capital amount per discharge.

Derivation of RY01 per discharge costs is described in **Section IV.B.2**.

For RY01, adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index for the period June 1, 1999 through May 31, 2000.

For RY01, adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, by 1.43% to reflect inflation between RY99 and RY00, and by 2.4% to reflect inflation between RY00 and RY01.

There will also be outlier payments for patients whose length of stay during a single Hospitalization exceeds twenty acute days.

Acute Hospitals which receive payment as Sole Community Hospitals shall be determined by the Division.

2. Specialty Hospitals and Hospitals with Pediatric Specialty Units

For RY01, the standard inpatient payment amount per discharge for Specialty Hospitals and Hospitals with Pediatric Specialty Units (as defined in **Section II**) shall be equal to the sum of:

> 95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount per discharge, adjusted for casemix and inflation; and the Hospital-specific FY01 pass-through amounts per discharge, direct medical

education amount per discharge and the capital amount per discharge. .

Derivation of RY01 per discharge costs is described in **Section IV.B.2**.

For RY01, adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index for the period June 1, 1999 through May 31, 2000.

For RY01, adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, 1.43% to reflect inflation between RY99 and RY00, and by 2.4% to reflect inflation between RY00 and RY01.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute Hospitals that receive payment as Specialty Hospitals and Pediatric Units shall be determined by the Division.

For Hospitals with Pediatric Specialty Units, the payment amount calculated under this section shall only apply to services rendered in the Pediatric Specialty Unit.

If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining rates in accordance with this section.

3. Public Service Hospitals and Municipal Hospital Providers

a. Public Service Hospital Providers

Public Service Hospitals shall be reimbursed for Inpatient Services as follows, and in accordance with **Section IV.C.3.b.**(1) For RY01, the standard inpatient payment amount per discharge for Public Service Hospital providers (as defined in **Section II**) shall be equal to the sum of:

95% of the Hospital's FY98 cost per discharge capped at 200% of the statewide average payment amount, adjusted for casemix and inflation; and the FY01 Hospital-specific pass-through amount per discharge, direct medical education

Derivation of RY01 per discharge costs is described in **Section IV.B.2**.

For RY01, adjustments were made for casemix by dividing the FY98 cost per discharge by the Hospital's FY98 all-payer casemix index and then multiplying the result by the Hospital's MassHealth casemix index for the period June 1, 1999 through May 31, 2000.

For RY01, adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 1.9% to reflect inflation between RY98 and RY99, by 1.43% to reflect inflation between RY99 and RY00, and by 2.4% to reflect inflation between RY00 and RY01.

There will also be outlier payments for patients whose length of stay during a single Hospitalization exceeds twenty acute days.

Acute Hospitals that receive payment as Public Service Hospitals shall be determined by the Division

b. Municipal Acute Hospital Providers

Municipal Acute Hospitals that do not also qualify as Public Service Hospitals shall be reimbursed in accordance with Sections IV.B and IV.C.3.c. herein.

c. Supplemental Payment

Subject to the availability of federal financial participation, the Division shall make a supplemental payment in addition to the standard reimbursement made under the Division's Acute Hospital Contract, to recognize Public Service and Municipal Acute hospitals' extraordinary costs of serving MassHealth members. Such lump sum payments are made annually at the end of the applicable fiscal year, or at such other times as the Division may determine. The payment amount will be (i) determined by the Division using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid costs and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.